# Demographic & Insurance Information Child Intake

Name: _____ Phone: _____

Age: _____ DOB: _____ Sex: _____ Phone (2): _____

Marital Status: _____ SSN: _____-_____-_____

Address: _____

_____

Email: _____

Emergency Contact: _____ Phone: _____

Email: _____

Address: _____

_____

Relationship to Patient: _____

Tranquil Healing Center, PS requires that ***all*** insurance coverage be pre-verified (3 business days) prior to providing insurance billing service for you. A $3.00 insurance billing fee will be charged per visit in addition to any co-pays, co-insurances, or other fees to provide this service for you. If verification has not been completed ahead of your appointment time, we will provide documentation of your visit to submit to your insurance company and waive the insurance billing fee.

## Insurance Information (primary)

Insurance Name: _____

Subscriber #: _____

Group #: _____

Plan Name: _____

Insured Name: _____

Relationship: _____ SSN of Primary: _____-_____-_____ DOB: _____

## Insurance Information (secondary)

Insurance Name: _____

Subscriber #: _____

Group #: _____

Plan Name: _____

Insured Name: _____

Relationship: _____ SSN of Primary: _____-_____-_____ DOB: _____

TRANQUIL Healing Center

# Financial Agreement Child Intake

Name: _____ DOB: _____ Date: _____

## Guarantor (person who is financially responsible):

Name: _____ DOB: _____ Gender: M F other

Phone: _____ SSN: _____-_____-_____

Address: _____

Email: _____

Relationship to Patient: _____

## Financial Responsibility Agreement

*Please initial each statement on the line provided in addition to signing and dating on the lines at the bottom of the page.*

**I understand and agree to the following general responsibilities:**

- I am responsible as the patient or patient ' s guarantor for full payment of services rendered at the time of service, including office visit fee, in-office lab test or procedures, medications administered, send-out labs, outstanding balances from previous visits/ services, and the $3.00 insurance billing fee ( if Tranquil Healing Center,PS is billing your insurance ) . _____
- I am responsible for providing all accurate and thorough documentation required to support any discounts I am receiving. _____
- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Tranquil Healing Center to release information necessary to secure payment. _____
- I am financially responsible for a flat fee of $30 for any appointment not cancelled within 24 hours of the appointment time and date, and will keep an up to date credit or check card on file to fulfill this responsibility. _____

**I understand and agree to the following with regards to insurance billing:**

- The pre-verification by Tranquil Healing Center, PS of my insurance benefits is used to determine if there is coverage for services through my insurance carrier and is NOT a guarantee of payment by my insurance carrier. _____
- I understand that Tranquil Healing Center, PS can require presentation of proof of insurance at any time. _____
- I understand that my insurance may need to be re-verified for specific coverage details as often as every six months. _____
- I am responsible for providing all accurate and thorough documentation required to verify my insurance coverage and / or bill my insurance carrier. _____
- I am responsible for full and timely payment of all insurance co-pays, deductibles, and co-insurance balances due, including any and all services not covered or paid by my insurance carrier. _____
- I forfeit the privilege of billing my insurance carrier if I do not comply with any of my financial responsibilities or documentation requirements. _____

I authorize release of information in my medical history to my insurance carrier and assign all benefits for unpaid services to the Tranquil Healing Center, PS and Dr. Terra Sowinski. This release applies to support of the insurance billing process only, records will not be released for any other reason without written consent of the patient. _____

**I have fully read and understand the above statements of financial responsibility, and by signing below, agree to abide by and authorize the actions stated there in.**

Printed Name: _____ (patient 18yo or older)

Guarantor Printed Name: _____

Signature: _____

Guarantor Signature: _____

Initials: _____ Date: _____

Initials: _____ Date: _____

TRANQUIL Healing Center

# Health History Form Child Intake

Name: _____ DOB: _____ Date: _____

Drug Allergies:_____

_____

_____

_____

## Current Medications

*Please itemize all medications you child is currently using or has used recently .*
*Please be sure to include all over the counter medications and hormones.*

| Drug Name | Reason for Use | Dose | How Long? | Prescriber |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Current Supplements

*Please list all vitamins. Minerals herbs, and other natural products your child is currently using or has used recently*

| Product Name | Reason for Use | Dose | How Long? | Prescriber |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

TRANQUIL Healing Center

# Health History Form Child Intake

Name: _____ DOB: _____ Date: _____

Height: _____ Weight: _____ Wt. 1 year ago: _____

What health concerns would you like Dr. Terra to help your child with? : _____

_____

_____

_____

_____

Rate your commitment ability to your child's healthcare needs.

Low 1 2 3 4 5 6 7 8 9 10 High

How long do you think it will take you to get well? Why? _____

_____

## Early Health History

Where there any problems during this child's pregnancy? Yes _____ No _____

If yes, please describe: _____

_____

Was he/she: ☐ breast fed? _____ mo / yr ☐ bottle fed? _____ mo / yr

Please check if he/she has had any of the following childhood illnesses:

☐ frequent ear infections ☐ colic ☐ eczema ☐ recurrent colds

☐ bronchitis ☐ pneumonia ☐ meningitis ☐ other

Where you on frequent or prolonged antibiotic therapy? ☐ Yes ☐ No

## Immunizations

☐ I have chosen not to vaccinate my child

Did he/she receive standard immunizations? ☐ Yes ☐ No

***Please provide a copy of his/her immunization record.***

Did he/she experience adverse reactions from immunizations? ☐ Yes ☐ No

If yes, what was the reaction? _____

Does he/she receive a regular influenza vaccination? ☐ Yes ☐ No

Does he/she have additional immunizations? (if yes, please list) ☐ Yes ☐ No

_____

_____

Name: _____ DOB: _____ Date: _____

## Health Procedures:

***Please check if you have had the following health maintenance procedures within the last 5 years, and please provide dates.***

- ☐ Full Physical Exam date: _____ Findings? _____
- ☐ Dental Exam date: _____ Findings? _____
- ☐ CBC, Chemistry, thyroid date: _____ Findings? _____
- ☐ Eye Exam: date: _____ Findings? _____
- ☐ EKG: date: _____ Findings? _____
- ☐ Other: _____ date: _____ Findings? _____
- ☐ Other: _____ date: _____ Findings? _____
- ☐ Other: _____ date: _____ Findings? _____

## Surgeries

| Date | Procedure | Reason | Outcome |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## Hospitalizations

| Date | Reason | Outcome |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## Diet: Please list a typical day's diet.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____ Beverages: _____

TRANQUIL Healing Center

# Health History Form Child Intake

Name: _____ DOB: _____ Date: _____

## Review of Systems

*Please Circle all that apply.*

**Y** = present condition **N** = never had the condition **P** = past problem **F** = Family member

**General**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Dizziness | Y N P F | Night Sweats | Y N P F | Fatigue | Y N P F | | |

**Head:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Headaches | Y N P F | Migraines | Y N P F | Jaw/ TMJ | Y N P F | Vision | Y N P F |
| Hearing | Y N P F | Smelling | Y N P F | Tasting | Y N P F | Dental | Y N P F |

**Skin**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Rashes | Y N P F | Eczema, hives | Y N P F | Color Changes | Y N P F | Moles | Y N P F |
| Skin Cancers | Y N P F | | | | | | |

**Musculoskeletal**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Joint pain | Y N P F | Muscle spasm | Y N P F | Weakness | Y N P F | Brakes/ Sprains | Y N P F |

**Neurologic**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Fainting | Y N P F | Numb/ tingling | Y N P F | Weak muscles | Y N P F | Seizures | Y N P F |
| Paralysis | Y N P F | Loss of memory | Y N P F | Neuropathy | Y N P F | | |

**Emotional**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mood swings | Y N P F | Nervousness | Y N P F | Tension/ stress | Y N P F | Anxiety | Y N P F |
| Depression | Y N P F | | | | | | |

**Endocrine**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Excessive Thirst | Y N P F | Cold intolerance | Y N P F | Thyroid issues | Y N P F | Diabetes | Y N P F |
| Excessive hunger | Y N P F | Heat intolerance | Y N P F | | | | |

**Cardiovascular / Respiratory**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Cough | Y N P F | Short of Breath | Y N P F | Asthma | Y N P F | Chest Pain | Y N P F |
| Abdominal pain | Y N P F | Blood clots | Y N P F | Heart disease | Y N P F | Low / high BP | Y N P F |

**Gastrointestinal**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Diarrhea | Y N P F | Constipation | Y N P F | Abdominal pain | Y N P F | Blood in stool | Y N P F |
| Nausea /Vomiting | Y N P F | BM per day | _____ | | | | |

**Urinary**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Incontinence | Y N P F | Infections | Y N P F | Painful urination | Y N P F | Stones | Y N P F |

**Males**

| | | | | | |
|---|---|---|---|---|---|
| Hernias | Y N P F | Testicular mass | Y N P F | Trauma / injury | Y N P |

**Female (if menstruating)**

Age of 1st Menses _____ Age last Menses _____ Length of Cycle _____ Duration Bleeding _____

Number of Pregnancies _____ Number of live Births _____ Number of Miscarriages _____ Number of Abortions _____

Birth Control Y N P If yes, what type? _____ How long? _____

Name: _____ DOB: _____ Date: _____

## Lifestyle Habits

***Please provide the following information:***

Does your child smoke? ☐ yes ☐ no

If yes, Packs per day? _____ How many years? _____

Smoker in your household? ☐ yes ☐ no

Does your child use recreational drugs? ☐ yes ☐ no

Former drug use? ☐ yes ☐ no If yes, please list: _____

Alcohol Use: ☐ none Type: _____ Amount/ frequency: _____

Schooling: ☐ home ☐ public ☐ other: _____ Grade: _____

Difficulty concentrating for long periods of time?: ☐ yes ☐ no

Difficulty learning certain subjects? ☐ yes ☐ no

If yes, please list: _____

Sleep Schedule: Time to bed _____ Time to wake _____ Naps _____

Sleep Quality: ☐ well rested ☐tired when waking ☐ awake during night

☐ sleep in total dark ☐sleep with some light in the room

Has he/she experienced physical, emotional, sexual or verbal abuse? ☐ yes ☐ no

If yes, is he/she under the care of a psychologist? ☐ yes ☐ no

My child's stress level is:

Minor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Severe

His/her main stressors in life are: _____

He/she relieves stress by: _____

What do you do to support your child's health: _____

_____

My child's obstacles to health are: _____

_____

_____

Name: _____ DOB: _____ Date: _____

## Environmental Sensitivities/ exposures

Does your child have adverse reactions to any of the following:

| | | | |
|---|---|---|---|
| Odors: | ☐ yes | ☐ no | reaction: _____ |
| Smoke: | ☐ yes | ☐ no | reaction: _____ |
| Soap: | ☐ yes | ☐ no | reaction: _____ |
| Fumes: | ☐ yes | ☐ no | reaction: _____ |
| Perfumes: | ☐ yes | ☐ no | reaction: _____ |
| Dust: | ☐ yes | ☐ no | reaction: _____ |
| Grasses: | ☐ yes | ☐ no | reaction: _____ |
| Pollen: | ☐ yes | ☐ no | reaction: _____ |
| Animals: | ☐ yes | ☐ no | reaction: _____ |
| Mold: | ☐ yes | ☐ no | reaction: _____ |

Has he/she been exposed to chemicals, now or in the past? ☐ yes ☐ no

If yes, which ones?: _____

Has he/she been exposed to heavy metals, now or in the past? ☐ yes ☐ no

If yes, which ones?: _____

Are there multiple electronic devices in his/her bedroom? ☐ yes ☐ no

Do you live near power lines or a power substation? ☐ yes ☐ no

## Additional Information

Please provide any additional information that you would like the doctor to know :

_____

_____

_____

*By signing below I confirm that the information provided on this form is truthful to the best of my knowledge. I give Tranquil Healing Center, PS and Dr. Terra Sowinski permission to use this information to assist in providing healthcare to me only (or the patient if guardian is signing) and securing payment from my insurance company if requested.*

_____ _____

Signature Date

_____

Printed Name